6/7/16

To:

From. Juel Roundtree #349150588l

RE: Exhibits and discreperancies in Medical record for 15-CV-8198 and/or deliberate falsifications

Please accepts these and notes on copies as proof of falsification of public records and/or manufacturing of false evidence.

These show the deliberate poor record keeping, negligence and professional malfeazance and malfeasance.

Corizon and the D.O.C. should be under investigation for this custom and practice of illegal records and evidence tampering.

Respectfully Submitted Juel Roundtree

Sworn to before me
this 7th day of June, 2016

Notary Public

LAKENYA A. JOHNSON
NOTARY PUBLIC-STATE OF NEW YORK
No. 01JO6221713
Qualified in Kings County
My Commission Expires 5/10/18

NYSID No: 06049698L **B&C No:** 3491505881

ROUNDTREE, JUEL
625 8TH AVE, 12B, NY, NY 10129

DOB: 02/03/1971 **Age:** 44 Y **Sex:** male

Primary Insurance: Medicaid
PCP:

Home:
Work:
Cell:
Email:
Advance Directive:

Allergies : N.K.D.A

* Never gave them permission to contact medicaid & gave no information * (HIPAA violation)

Medical History

Active Problem List

Code	Name	Specify	Notes	Added On	Modified On	Modified By
RI50	SMI - NO			06/02/2015	06/02/2015	Villar, Ofelia
493.90	ASTHMA NOS				06/02/2015	Villar, Ofelia
714.9	Arthralgias	Multiple joints, LE>UE			03/14/2015	Appiah, Charles
278.00	OBESITY NOS				06/02/2015	Villar, Ofelia
V70.0	ROUTINE MEDICAL EXAM				05/27/2015	Grandoit, Jean
338.21	CHRONIC PAIN DUE TO TRAUMA		orthopedic appt on 7/2,was started on neurontin 2 days ago ,d/c naproxen,start tramadol.Pt was on 50mg qid on the st,will order100mg bid		06/17/2015	Georges, Marie
530.81	GERD				06/02/2015	Villar, Ofelia
836.2	TEAR MENISCUS NEC-CURREN				05/27/2015	Grandoit, Jean
726.2	SHOULDER REGION DIS NEC				10/29/2013	Parks, Scott
300.9	Psychiatric disorder or problem				07/26/2013	Pedestru, Cristian
309.0	Adjustment disorder with depressed mood				05/27/2015	Grandoit, Jean
295.70	SCHIZOAFFECTIVE DIS NOS				05/27/2015	Grandoit, Jean
799.9	Diagnosis deferred				07/31/2013	Frey, Matthew
312.30	Impulse control disorder, unspecified				05/27/2015	Grandoit, Jean
295.72	Schizoaffective disorder, chronic				06/02/2015	Villar, Ofelia
301.7	Antisocial personality disorder				06/02/2015	Villar, Ofelia
726.10	Rotator cuff syndrome NOS				05/27/2015	Grandoit, Jean

NYSID No: 06049698L **B&C No:** 3491505881

ROUNDTREE, JUEL
625 8TH AVE, 12B, NY, NY 10129

DOB: 02/03/1971 **Age:** 44 Y **Sex:** male

Primary Insurance: Medicaid
PCP:

Home:
Work:
Cell:
Email:
Advance Directive:

Allergies : N.K.D.A

521.00	Dental caries NOS			09/04/2013	Jimoh, Saidu
715.98	OSTEOARTHRO NOS-OTH SITE	mild osteoarthritis as per x-ray		06/17/2015	Georges, Marie
V72.2	Dental examination			09/18/2013	Satter, Quazi
525.9	Toothache			10/16/2013	Jones, Vanessa
796.2	Elevated blood pressure reading without diagnosis of hypertension			05/27/2015	Grandoit, Jean
784.99	Halitosis			10/17/2013	Devivo, Lynn
472.0	Rhinitis NOS			10/29/2013	Parks, Scott
520.6	Impacted tooth			10/30/2013	Satter, Quazi
E958.8	INJURY-NEC			11/30/2013	Ihenacho, Gloria
920	Contusion of scalp			11/30/2013	Ihenacho, Gloria
536.8	Indigestion NOS			12/03/2013	Tse, Marshall
368.8	Blurred vision NOS		12/07/2013	12/07/2013	Umeozor, Augustine
V85.39	BMI 39.0-39.9,ADULT		05/27/2015	05/27/2015	Grandoit, Jean
304.80	Polysubstance dependence, unspecified		06/02/2015	06/02/2015	Villar, Ofelia

Medications

Name strength formulation, Sig: take route frequency
Neurontin 300 MG Capsule, Sig: 3 capsules Orally Twice a Day Start Date: 07/13/2015
Ibuprofen 400 MG Tablet, Sig: 2 tabs Orally Daily PRN with food Start Date: 07/15/2015
Tramadol HCl 50 mg Tablet, Sig: 2 tabs Orally Twice a Day Start Date: 07/15/2015
Zantac 150 MG Tablet, Sig: 1 tab Orally Twice a Day Start Date: 05/27/2015
Ventolin HFA 108 (90 Base) MCG/ACT Aerosol Solution, Sig: 2 puffs Inhalation Every 6 Hours, as needed Start Date: 05/27/2015

Violence
ever hit or assaulted anyone *Yes*
ever been charged with sexual offense *No*
ever been assaulted *Yes*
ever been a victim of sexual abuse *Yes*
Education
grade level completed *some college*
learning disability *No*
were you in special education *No*
Sexual history
sexually active with *women*
current number of sexual partners *3*
do you and your partner use condoms *No*

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
skin grafts both hands 2003
MVA 08/2012

ER visits in the last year *No*
TB History
Have you ever had active TB *no*
History of positive Tuberculin Skin Test *No*
TB symptoms *None*
Recent exposure to TB *no*
No history of TB or LTBI *Asymptomatic*
HIV History
HIV/AIDS *no*
have you ever been tested for HIV *Yes*
date last tested *2/2015*
result of last test *negative*
do you want to have HIV test today *yes*
Mental Health History
Mental health or Nervous problems *Yes*
What type *Schizophrenia,Other*
Required hospitalization *Yes*
when last hospitalized *1984*
where *UPSTATE NEW YORK*
in treatment *No*
Ever tried to hurt or kill yourself *no*
family history of mental illness *Yes*
who *mother*
family history of suicide *No*
Trouble falling or staying asleep *Yes*
Changes in appetite or eating habits *Yes*
You feel hopeless or worthless *No*
Little interest or pleasure in doing things *Yes*

TEMPLATES:

New Admission MDC/VCBC/RNDC/OBCC

Ebola Virus Disease (EVD) Screening:
Ebola Virus Disease (EVD) Screening
Travel to a country with widespread EVD transmission (Guinea, Sierra Leone) in the last 21 days? *No*
Exposure to known or suspected Ebola patient in the last 21 days? *No*

COMMUNITY MEDICATION FILL HISTORY:
Did you check Community Medication Fill Database?
Did you check Community Medication Fill Database? *Yes*
Community Medication Fill History Results (Copy/Paste from Database) /CYCLOBENZAPRINE, 60 10MG TABLETS - TK 1 T PO BID MDD 2 TS 59746017710 6/12/2014
HYDROCHLOROTHIAZIDE, 30 12.5MG CAPSULES - TK 1 C PO ONCE D 59746038210 6/12/2014
HYDROCODONE -ACETAMINOPHEN, 60 5-325 TB - TK ONE T PO Q 4 TO 6 H. MDD 4 TS 00591320205 6/9/2014
MELOXICAM, 30 15MG TABLETS - TK 1 T PO ONCE D 68180050203 6/12/2014
OXYCODONE-ACETAMINOPHEN, 120 10-325MG TB - TK 1 T PO QID. MDD 4 TS 00228298311 7/25/2014
TRAMADOL, 120 50MG TABLETS - TK 1 T PO QID MDD 4 TS 68382031910 6/12/2014

Deprived of these Necessary Medications

123/79	12:28:38 AM	Shaw
Pulse		
76	05/27/2015 12:28:38 AM	Omolola Olufunmilayo-Shaw
RR		
16	05/27/2015 12:28:38 AM	Omolola Olufunmilayo-Shaw
Temp		
98.1	05/27/2015 12:28:38 AM	Omolola Olufunmilayo-Shaw
Peak Flow		
400	05/27/2015 12:28:38 AM	Omolola Olufunmilayo-Shaw
SaO2		
100	05/27/2015 12:28:38 AM	Omolola Olufunmilayo-Shaw

extremely inadequate Painkillers

0120AM PT MEDICATED WITH NAPROSYN 500MG P.O. AND ROBAXIN 500MG P.O. AS PER MD ORDERS. PT TEACHING DONE. PT DENIES ANY DRUG ALLERGIES. PT VERBALISE UNDERSTANDING. OS LPN.

Past Orders

Urine Drug Screen (Order Date - 05/26/2015) (Collection Date - 05/27/2015)

Never gave Permission for drug Screening & was not Notified "Illegal"

Result: Abnormal/Positive/Reactive

Cocaine	pos
Meth	neg
Opiates	neg
Benzos	neg

Notes: Jacob,Lena , PCA 5/27/2015 12:55:33 AM > Specimen collected

Physical Examination

General Appearance:
- General Appearance: Normal.
- Hygiene: unremarkable.
- Ill-appearance: none.
- Mental Status: alert and oriented.
- Mood/Affect: euthymic.
- Race: african-american.
- Speech: unremarkable.
- Eye contact: normal.
- Build: obese .

BACK:
- Spine: normal spine curvature.
- General: unremarkable.
- ROM: FROM without pain. *lie* Pain from metal benches

HEENT:
- Head: normocephalic, atraumatic.
- General Normal.

Eyes: PERRLA, EOMI.
Fundi: disc not visualized.
Ears: external ear unremarkable.
Nose: no deviation.
Throat: no exudate.
Oral cavity: no lesions seen, moist mucosa , no thrush.

NECK:
General: supple.
Cervical lymph nodes: nontender.
Thyroid: no thyromegaly.

CHEST:
Shape and expansion: normal, no chest wall tenderness.
Scar: not present.
General normal.

DERMATOLOGY:
Skin: warm, and moist.
General Normal.

BREASTS:
General symmetric, no abnormal skin changes.
Gynecomastia: not present.

LUNGS:
Auscultation: CTA bilaterally, no wheezing/rhonchi/rales.
General Normal.
Airflow: normal air movement.
Rate: regular.
Percussion: normal.
Effort: no respiratory distress, comfortable breathing.

HEART:
Rate: regular.
General Normal.
Rhythm: regular.
Heart sounds: normal S1S2.
Murmurs: none.
PMI: normal.

ABDOMEN:
General soft, nontender, BS +,.
Auscultation: normal bowel sounds.
Palpation soft, nontender, no guarding.
Scars: none.

RECTUM/ANUS:
Digital Rectal Exam Refused. * Never offered * Deliberate Lie

GU - MALE:
General Normal.
External genitals: no lesions, normal scrotum and penis.
Penis: no penile discharge, no penile lesions.
Scrotum: nontender.
Testicles: descended bilaterally.

EXTREMITIES:
General: no visible deformities, full range of motion. lie never examined
Pulses: 2+ bilateral. PAIN from metal benches

MUSCULOSKELETAL:
Joints Demonstration: apparent normal usage/shape .

SKIN:

Form 330 ADM (CC) (10/11)

State of New York
COMMISSION OF CORRECTION
Office of Mental Health

SUICIDE PREVENTION SCREENING GUIDELINES

DETAINEE'S NAME	SEX	DATE OF BIRTH	MOST SERIOUS CHARGE(S)	DATE	TIME
Roundtree Jr.	M	2/3/71	121.12	5/26/15	

NAME OF FACILITY	NAME OF SCREENING OFFICER	Does detainee have prior ADM 330 on file. YES ☐ If yes, review NO ☐
MDC	[illegible]	

Book and Case#	Check appropriate column for each question	NYSID #
54 915C5881		04169 8L

	Column A YES	Column B NO	General Comments/Observations All "YES" Responses Require Note to Document
OBSERVATIONS OF ARRESTING/TRANSPORTING OFFICER			
1. Arresting or transporting officer believes or has received information that detainee may be a suicide risk. **If YES, notify supervisor.**		✓	
PERSONAL DATA			
2. Detainee lacks support of family or friends in the community.	No Family Friends	✓	
3. Detainee has experienced a significant loss within the last six months (e.g., loss of job, loss of relationship, death of close family member).		✓	
4. Detainee is very worried about major problems other than legal situation (e.g., serious financial or family problems, a medical condition or fear of losing job).		✓	
5. Detainee's family member or significant other (spouse, parent, close friend, lover) has attempted or committed suicide.		✓	
6. Detainee has history of drug or alcohol abuse. **(Note drug and when last used.)**		✓	
7. Detainee has history of counseling or mental health evaluation/treatment. (Note current psychotropic medications and name of most recent treatment agency.)		✓	
8. Detainee expresses **EXTREME** embarrassment, shame, or feelings of humiliation as result of charge/incarceration (ie. Are you worried arrest/incarceration will cause embarrassment for self or family?) **If YES, notify supervisor.**		✓	
9. Detainee is thinking about killing self. **If YES, notify supervisor.**		✓	
10a. Detainee has previous suicide attempt. (Explore method and check for scars.)		✓	
b. Attempt occurred within last year. **If YES, notify supervisor.**		✓	
11. Detainee is expressing feelings of hopelessness (nothing to look forward to). **If YES, notify supervisor.**		✓	
12. This is detainee's first incarceration in lockup/jail.		✓	
BEHAVIOR/APPEARANCE			
13. Detainee shows signs of depression (e.g., crying, emotional flatness).		✓	
14. Detainee appears overly anxious, panicked, afraid or angry.		✓	
15. Detainee is displaying unusual behaviors or is acting and/or talking in a strange manner. (e.g., cannot focus attention; hearing or seeing things which are not there).		✓	
16a. Detainee is apparently under the influence of alcohol or drugs.		✓	
b. Detainee self reports or is showing signs of withdrawal from alcohol or drugs.		✓	
c. Detainee is incoherent, disoriented, or showing signs of mental illness. **If YES to b or c, notify supervisor.**		✓	

TOTAL Column A _____

Officer's Comments / Impressions

* Never asked *

ACTION

If total checks in Column A are 8 or more, or any shaded box is checked, or if you feel it is necessary, institute constant supervision and notify supervisor.

Constant Supervision Instituted: YES _____ NO ✓

Supervisor Notified: YES _____ NO _____

Detainee Referred to Medical / Mental Health: YES _____ NO _____	EMERGENCY	NON-EMERGENCY
If YES:	medical _____	medical _____
	mental health _____	mental health _____

Signature and Badge Number of Screening Officer: [illegible] Jean Grandoit PA

Signature and Badge Number of Supervisor: (If required)

WHITE: (Facility File) YELLOW: (Medical/MH Referral or Facility Transfer)

Over

NYC Health
Correctional Health Services

Manhattan Detention Center

125 White Street
New York NY 10013
Ph: Fax:

Initial Intake Form

Name: ROUNDTREE, JUEL **Date:** 05/27/2015

*** Current medical provider**

- ☐ hospital clinic
- ☐ community health center
- ☐ VA hospital
- ☑ private MD
- ☐ emergency room
- ☐ jail/prison
- ☐ other
- ☐ none

Name/address of medical provider

DR LAZARFEYGIN, PT DOES NOT REMEMBER MD ADDRESS

*** when last seen by medical provider**

- ☐ < week ago
- ☐ < month ago
- ☑ 1-6 months ago
- ☐ 7-12 months ago
- ☐ 1-3 years ago
- ☐ > 3 years ago
- ☐ don't know

*** disabilities**

- ☑ Yes
- ☐ No

*** type**

- ☐ blind, one eye
- ☐ blind, both eyes

- [ ] deaf
- [ ] hard of hearing/use hearing aide
- [ ] mute
- [ ] hemiplegia, right
- [ ] hemiplegia, left
- [ ] quadriplegia
- [ ] paraplegia
- [ ] amputee
- [x] other

(specify)

BL KNEE SURGERY, BAD ANKLE AND SHOULDER

Never Had surgery
Never said I did
Inaccurate Medical Record
Reported torn meniscus both knees

use an assistive device

- [ ] wheelchair
- [x] cane
- [ ] crutch
- [ ] prosthetic
- [ ] brace
- [ ] other
- [ ] none

*** chickenpox**

- [ ] yes
- [x] no
- [ ] don't know

*** STD**

- [x] Yes
- [ ] No

type

- [ ] chlamydia
- [x] gonorrhea
- [ ] syphilis
- [ ] herpes

- [ ] genital warts
- [ ] anal warts
- [ ] trichomonas
- [ ] other
- [ ] don't know

treated

- [x] Yes
- [ ] No

*** hypertension**

- [ ] Yes
- [x] No

*** heart disease**

- [ ] Yes
- [x] No

*** diabetes**

- [ ] Yes
- [x] No

*** seizures**

- [ ] Yes
- [x] No

*** Liver disease**

- [ ] Yes
- [x] No

*** kidney disease**

- [ ] Yes
- [x] No

*** cancer**

- [ ] Yes
- [x] No

Next >> Save & Next >>

NYC Health
Correctional Health Services

ROUNDTREE, JUEL

44 Y old Male, DOB: 02/03/1971
625 8TH AVE, 12B, NY, NY 10129
Provider: Madhava, Valsa, MD

Telephone Encounter

Answered by eclinicalworks, support (PROD)

Date: 06/01/2015
Time: 10:33 PM

Reason Chart Review - Facility Transfer

Reason for Appointment
1. Chart Review - Facility Transfer

History of Present Illness
TEMPLATES:

Transfer Chart Review .
Patient Chart Reviews:
Transfer Chart Review
Intake History and Physical Completed (If NOT, Schedule an INTAKE appointment)? *Yes /*
DID the Patient Refuse Intake? *No /*
IS or SHOULD patient be in MEDICAL ISOLATION (Requires Daily Rounds)? *No /*
.
Pending or Missed Labs or DI's? *No /*
All necessary Labs and DI's have been ordered? *Yes /*
QFT result present and appropriately addressed: *Yes /*
Reschedule MISSED Follow-up visits at new facility: *Yes /*
Patient has DOT Medications and/or Insulin orders (If So Please Reorder)? *No /*
Is the patient being transfered from NIC/CDU (If YES, review discharge note and reorder medication)? *No /*
Does the Patient require Heat Sensitive Housing (If yes, print Heat Sensitivity Form)? *No /*
Special Dietary Requirements? (If yes, re-order dietary prescription and/or consult) *No /*
Reorder Dietary Prescription and/or consult (FOR FOOD ALLERGY/ SPECIAL DIET/ FOOD SUPPLEMENT) : *N/A /*
History of Present Illness (narrative assessment -- free text in Notes field) /
Consults reviewed? *Yes /*
Description of pertinent lab/DI abnormalities (free text in Notes field) /
.
Is the patient on Suicide Watch? *No /*
IF on Suicide Watch, Refer to Mental Health: *N/A /*
IF on Sucide Watch, Is there a TN form? *N/A /*

Current Medications
None → lie-painkillers & Zantac 150 * Inaccurate Medi records * Rush job to Clear me for Gen. Population

Past Medical History
Disabilities from knee disorders walk with a can

no JVD.
HEART: HEART SOUNDS:-, normal S1S2, MURMURS:-, none.
LUNGS: good air exchange, clear to auscultation bilaterally.
ABDOMEN: soft, NT/ND, BS present.
EXTREMITIES: right hip graft, and hands palmar thick skin limited left shoulder on raising upper extremity,left knee chronic swelling, no tenderness,limited extension.

Assessments

1. CHRONIC PAIN DUE TO TRAUMA - 338.21, orthopedic appt on 7/2,was started on neurontin 2 days ago ,d/c naproxen,start tramadol.Pt was on 50mg qid on the st,will order100mg bid
2. OSTEOARTHRO NOS-OTH SITE - 715.98, mild osteoarthritis as per x-ray

Treatment

1. CHRONIC PAIN DUE TO TRAUMA

Start Tramadol HCl Tablet, 50 mg, 2 tabs, Orally, Twice a Day, 7 days, Pharmacy
Stop Naproxen Tablet, 250 MG, 2 tabs, Orally, Twice a Day, 7 days, Pharmacy

Electronically signed by Marie Georges MD on 06/17/2015 at 03:38 PM EDT

Sign off status: Completed

George R. Vierno Center
09-09 Hazen Street
East Elmhurst, NY 11370
Tel: 718-546-2107
Fax:

NYC Health
Correctional Health Services

ROUNDTREE, JUEL

44 Y old Male, DOB: 02/03/1971
625 8TH AVE, 12B, NY, NY 10129
Provider: Cherchever, Arkady

Telephone Encounter

Answered by Cherchever, Arkady

Date: 07/15/2015
Time: 02:06 PM

Reason Medication Renewal

Medication Start Tramadol HCl Tablet, 50 mg, Orally, Pharmacy, 2 tabs, Twice a Day, 7 days
Start Ibuprofen Tablet, 400 MG, Orally, Pharmacy, 2 tabs, Daily PRN with food, 7 days, Refills=0

Reason for Appointment
1. Medication Renewal

Current Medications
Ventolin HFA 108 (90 Base) MCG/ACT Aerosol Solution 2 puffs Every 6 Hours, as needed, stop date 08/25/2015
Zantac 150 MG Tablet 1 tab Twice a Day, stop date 08/25/2015
Tramadol HCl 50 mg Tablet 2 tabs Twice a Day, stop date 07/16/2015
Neurontin 300 MG Capsule 3 capsules Twice a Day, stop date 07/27/2015

Past Medical History
Disabilities from knee disorders walk with a can
STD
Asthma hx
GERD hx
Rotator cuff syndrome hx
Osteoarthritis hx
Obesity
Chronic pain hx

Allergies
N.K.D.A.

Assessments
1. CHRONIC PAIN DUE TO TRAUMA - 338.21

Treatment
1. CHRONIC PAIN DUE TO TRAUMA
Start Tramadol HCl Tablet, 50 mg, 2 tabs, Orally, Twice a Day, 7 days, Pharmacy
Start Ibuprofen Tablet, 400 MG, 2 tabs, Orally, Daily PRN with food, 7 days, Pharmacy, Refills 0

Patient: ROUNDTREE, JUEL DOB: 02/03/1971 Provider: Cherchever, Arkady 07/15/2015

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

NYC Health
THE NEW YORK CITY DEPARTMENT OF MENTAL HYGIENE AND MENTAL HYGIENE

CORRECTIONAL HEALTH SERVICES
COMPLAINT

Please fill out this form and drop it in the Second Opinion/Complaint Box in your facility. If you need help completing the form, ask a medical or mental health staff member.

Information about you (please print)

Name Jvel Roundtree Book & Case Number 349.150.5881

Facility GRVC Housing Area 9B

What is your complaint? (Tell us what happened. Give as much information as you can, including which staff members were involved. Sign and date the form.)

When did this happen? 6/3 - today Where did this happen? GRVC

What happened? (Please print clearly.)

I am being given substandard care even though my numerous medical conditions are known. #1. due to my numerous injuries I should not be a max classification or housed in housing areas known to be dangerous or turbulent. I am being housed in such an area. I am not allowed to use my cane and with no chairs. The seating is a small round steel disk attached to a dangerous steel picnic bench style table. I am too big to sit comfortably, and am always in pain sitting on them. My back is on fire after sitting on these steel discs and I also require much stronger pain killers and more specialized care. I should never have been moved here.

Signature Jvel Roundtree Date 6/10/2015

6356

FOR OFFICIAL USE ONLY
DATE RECEIVED _____

TRACKING NUMBER _____

CHS# 359 (09/07)

NYC Health
THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CORRECTIONAL HEALTH SERVICES
COMPLAINT

Please fill out this form and drop it in the Second Opinion/Complaint Box in your facility. If you need help completing the form, ask a medical or mental health staff member.

Information about you (please print)

Name Juel Roundtree Book & Case Number 349, 150, 5881

Facility GRVC Housing Area 9B

What is your complaint? (Tell us what happened. Give as much information as you can, including which staff members were involved. Sign and date the form.)

When did this happen? 6/2015 - Now Where did this happen? GRVC

What happened? (Please print clearly.)

My medical circumstances are being completely disregarded, as I am being forced to remain in a bldg. in a perpetual state of violent upheaval that is extremely unsafe for a disabled person, such as my self. I have been forced to ambulate without my cane, up & down stairs, even though I should not be using stairs. I'm not being given strong enough painkillers and it is extremely problematic for me. I have been denied transport to sick call by certain officers and I should be in a medical house such as the housing in the 4 bldg. for older people like myself.

Signature Juel Roundtree Date 6/15/2015

FOR OFFICIAL USE ONLY
DATE RECEIVED _____

TRACKING NUMBER 5516

CHS# 359 (09/07)

Request for Dental Care

If you need a Dental appointment, you do not need to visit the clinic. Please complete all the boxes on this form and place the completed form in the **Over-the-Counter *Medication Request box.***

The Dental Department will schedule an appointment for you and will arrange to have you brought to the Dental clinic.

Name:	Juel Roundtree
Book & Case Number:	349.150.5881
Date of Birth:	2/3/71
Housing Unit:	9B GRVC

Juel Roundtree		6/10/2015
Signature		**Date**

Peticion Para Servicios De Cuidados Dentales

Si usted necesita una cita Dental, Usted no necesita visitar la Clinica. solamente tiene que completar la informacion pedida en el formulario y depositarlo en la *Caja Para Solicitar Medicamentos.*

El Departamento Dental le dara una cita y facilitara todo lo necesario para que usted este presente en la Clinica Dental el dia de la cita.

Nombre:	
Numero de Caso:	
Fecha de Nacimiento:	
Unidad de Alojamiento:	

Firma		**Fecha**

care Not received until March, 2016
Then substandard botched job

Addressed
K. MAXIMIN
7/7/2015

Request for Aftercare Letter

If you need an Aftercare Letter, you do not need to visit the clinic. Please complete all the boxes on this form and place the completed form in the Over-the-Counter *Medication Request box*.

You will be called to the clinic when your Aftercare Letter is completed. Your Aftercare Letter will be given to you in a sealed envelop by the clinic officer.

Name:	Juel Roundtree
Book & Case Number:	349150 5881
Date of Birth:	2/3/71
Housing Unit:	9B GRVC

Signature		6/10/2015
		Date

Peticion De Cartas para Cuidados Postoperatorios

Si usted necesita una *Carta De Cuidados Postoperatorios*, Usted no necesita visitar la clinica, solamente tiene que completar la informacion pedida en el formulario y depositarlo en la *Caja Para Solicitar Medicamentos*.

Usted sera citado a la clinica cuando su carta de Cuidados Postoperatios este lista. La Carta sera entregada personalmente a usted por un Official de la clinica en un sobre sallado.

Nombre:	
Numero de Caso:	
Fecha de Nacimiento:	
Unidad de Alojamiento:	

Firma		**Fecha**

NYC Health
THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CORRECTIONAL HEALTH SERVICES
COMPLAINT

Please fill out this form and drop it in the Second Opinion/Complaint Box in your facility. If you need help completing the form, ask a medical or mental health staff member.

Information about you (please print)

Name Jue l Roundtree Book & Case Number 349 150 5881

Facility GRVC Housing Area 9B28

What is your complaint? (Tell us what happened. Give as much information as you can, including which staff members were involved. Sign and date the form.)

When did this happen? 6/15/15 – Now Where did this happen? GRVC

What happened? (Please print clearly.)

I don't know if a joke is being played on me or not but, I was asked if I was (by Correction staff) familiar with tramadol & the dosage if any I had taken before. That dosage was 400 mg tramadol & 10mg percocet interspersed between the 400 mg tramadol ever 4 hours I received. I was instead given 50 mg of tramadol, which is not even worth the pain of walking to medication, since it has absolutely no affect whatsoever. I'm done complaining I'm going to go way over this facility & Corizon's head. I refuse to allow you to put me through undue stress and extreme pain any longer. This is negligence to the highest degree.

Signature Jue l Roundtree Date 6/21/15

FOR OFFICIAL USE ONLY
DATE RECEIVED _____

TRACKING NUMBER 0366

CHS# 359 (09/07)

If you need this response to be translated, please ask clinic staff for help in finding a translator.
Si usted necesita esta respuesta sea traducida, por favor pida ayuda al personal de la clinica para encontrar un traductor.

NYC Health
THE NEW YORK CITY DEPARTMENT of HEALTH AND MENTAL HYGIENE

CORRECTIONAL HEALTH SERVICES
RESPONSE TO COMPLAINT

Complaint Number
Inmate Name Poundtree, Juel
Facility GMAC
Received On 07/09/15
Book & Case Number 349150588J
Housing Area 15

We have investigated your complaint. Here is what we found:

Your complaint for pain in your arm and head to review medical history

I can't read this!!

We have taken the following actions (*Responder—if none, so indicate*):

Your provider and supervisor does have ordered orthopedic evaluation not requested

Name of Responder Dr. Hershfield Date 07/13/15

If you are not satisfied with how we have responded to your complaint, you may file an appeal in the Second Opinion/Complaint box. You must do so within seven (7) days of the date you received this response.

The person who made the complaint has received a copy of this response:

Name of Inmate Poundtree, Juel Book & Case Number 349150588J
Signature of Inmate [signature] Date 07/13/15

FOR OFFICIAL USE ONLY

TRACKING NUMBER 3560

CHS# 360 (11/07)

Have No idea what this says

DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

PATIENT REFUSAL OF TREATMENT

PATIENT'S LAST NAME	FIRST NAME		NYSID NUMBER	
ROUNDTREE	JUEL		06049698L	
BOOK AND CASE NUMBER	**DATE**	**TIME**	**FACILITY**	**DATE OF ADMISSION**
3491505881	07/07/2015	11:38:57 AM	George R. Vierno Center	05/26/2015 16

This is to certify that I am over the age of eighteen (18) years of age and I am refusing the following:

- ☐ MEDICAL EVALUATION [HISTORY AND PHYSICAL]
- ☐ MEDICAL SERVICES
- ☐ ADMINISTRATION OF MEDICATION (OTHER THAN PSYCHIATRIC)
- ☐ LABORATORY SERVICES ☐ X-RAY SERVICES
- ☐ HEAT SENSITIVE HOUSING
- ☐ OTHER (SPECIFY): _____
- ☐ MENTAL HEALTH EVALUATION
- ☐ MENTAL HEALTH SERVICES
- ☐ ADMINISTRATION OF PSYCHIATRIC MEDICATION
- ☐ DIAGNOSTIC TESTING
- ☑ CLINICAL APPOINTMENT AT: WF Physical Therapy

I understand this refusal is against the advice of my health care practitioner. I acknowledge that I have been informed of the risks, consequences and the danger to my health and possibly to my life which may result from my refusal of this procedure/treatment. I have been given time to ask questions about my condition and about my decision to refuse the procedure/treatment which my health care provider has explained to me is medically indicated and necessary.

I voluntarily assume the risks and accept the consequences of my refusal of the procedure/treatment and I am releasing all of the health care providers, the facility and its staff from any and all liability for ill effects that may result from my refusal of treatment.

Signature of Patient

07/07/2015
Date

The above named patient refused the procedure/treatment, which is medically indicated, and necessary. I explained to the patient, the risks, consequences and dangers of refusing the procedure/treatment include but are not limited to the following:

Bus was tiny, I couldn't fit

I provided the above named patient with the opportunity to ask questions, I have answered the questions asked and it is my professional opinion that the patient understands what I have explained.

Pravin Ranjan, MD
Print Name of Attending Physician or Authorized Health Care Provider

07/07/2015
Date

Signature of Attending Physician or Authorized Health Care Provider

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Juel Roundtree #349150588l
(GRVC) 09-09 Hazen st
E. Elmhurst, N.y. 11370

USM P3
SDNY

The Honorable Loretta A. Preska
S.D.N.Y. U.S. Dist. Court
500 Pearl st. PRO-SE INTAKE
Ny Ny 10007

2015 JAN 14 PM 12:36